STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155344	A. BUILDING 00 B. WING	03/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00087416. This visit was done in conjunction with the Recertification and State Licensure Survey. Complaint IN00087416 - Substantiated. Federal/State deficiencies related to the allegation are cited at F223, F225, and F226. Dates of Survey: March 21, 22, 23, 24, 25, and 28, 2011 Facility Number: 000236 Provider Number: 155344 AIM Number: 100287700 Survey Team: Heather Tuttle, RN. TC. Lara Richards, RN. Janet Adams, RN. Kathleen Vargas, RN. Census Bed Type: 89 SNF/NF 89 Total Census Payer Type: 24 Medicare 56 Medicaid	F0000	Note: This provider wishes this Plan of Correction to be considered as our credible allegation of compliance. Preparation and/or execution of this Plan of Corrections does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of the Federal and State laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	9 Other 89 Total Sample: 40 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 4/04/11 by Suzanne Williams, RN			
F0223	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.			
SS=D	Based on record review and interview, the facility failed to ensure each resident was free from verbal abuse related to staff to resident verbal abuse as witnessed by a dietary employee for 1 of 4 allegations of abuse reviewed for 1 of 4 residents reviewed for abuse in the sample of 40. (Resident #B) Findings include: The allegation of verbal abuse for Resident #B was reviewed on 3/25/11 at 10:30 a.m. The incident date was Sunday 9/26/10. The brief description of the incident was the resident was in the dining room when a nurse (named), talking in a loud voice, told the resident to eat "because she was not going to lose weight on her watch." The immediate action taken was an investigation was started, Executive Director notified, employee suspended, physician	F0223	F223 Resident B has been discharged from facility. The LPN is no longer employed by facility. 2.) All residents have the potential to be affected by the same deficient practice.Allegations of abuse will be reported to Indiana Department of Healthand investigated immediately by ED/Designee. **The facility policy on "Reporting Alleged Abuse" was amended to include "failure to report alleged abuse immediately upon occurrence or allegation will result in corrective action."** 3.) Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on types of abuse, reporting abuse, procedures of and investigation of abuse by	04/27/2011

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	notified and family notified. The preventative measures taken were to have Social Service follow up with the resident and to re-educate staff on the abuse policy. Review of the witness interview form dated 9/29/10 by the dietary employee who witnessed the verbal abuse indicated "I (name) observed a staff member telling a resident that she at least has to eat 50% of her dinner or she couldn't be moved out of dining room or could not go to bed. She also stated she wasn't gonna allow her to lose weight on her watch. Then I left out of the dining room to go back to the kitchen. I came back to clean the dining room. I heard the resident crying (she always does) and the same staff member (name) came into give meds and she asked her to stop crying and if she doesn't, her aide will get mad at her and not put her to bed." Review of another witness interview dated 9/29/10 by the dietary supervisor on duty on Sunday 9/26/10 indicated "Dietary Aide (name) want to ask me a question about if someone could force a resident to eat. She stated that (name) told resident that she had to eat 50% of her food or she would have to sit up in dining room she was not going to be a weight loss on her watch. She told me I had to report to (name) my supervisor." Review of another witness statement dated 9/30/10 by the a.m. supervisor/cook indicated on Monday 9/27/10 (name) came to me about some abuse she witnessed on Sunday 9/26/10. She told me she had told (name) supervisor/p.m., after she witnessed it. (Name) Dietary Manager was not here and (name) the p.m., supervisor would not be here		Nursing Administration**. Staff will be in-serviced monthly for 3 months and quarterly thereafter on reporting potential abuse immediately to ED/Designee. DON/Designee will audit 24 hour report daily M-F for potential abuse, incidents and accidents and review resident, family and staff complaints. The ED/DON is on call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet for immediate notification. All new staff will be informed of abuse policies in orientation and in ongoing education.** 4.) Allegations of abuse will be reported to Performance Improvement Committee monthly. Tracking and trending will be monitored in Performance Improvement.5.) The DON is responsible for ensuring ongoing compliance.Compliance date 04/27/11.	

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	Monday either. I told her we would not wait for them so we went to (name) the ADON on that Monday and reported everything to her, she took her statements and said she would investigate the matter. Review of the Suspension Form indicated the LPN was suspended on 9/29/10 three days after the incident. Review of the Termination form indicated on 10/4/10 the employee was terminated from employment. Interview with the DON on 3/25/11 at 11:30 a.m., indicated she was not employed at the time of the incident, and the Administrator at that time was no longer employed at the facility. The DON further indicated the allegation of verbal abuse was substantiated by the facility. **This federal tag relates to complaint IN00087416.** **3.1-27(b)**			
F0225	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or			

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	abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
SS=D	Based on record review and interviews, the facility failed to ensure every allegation of abuse was reported immediately to the Administrator and every resident was protected during the investigation for 2 of 4 allegations of abuse reviewed for 2 of 4 residents reviewed for abuse in the sample of 40. (Resident #B and #C) Findings include: 1. Review of the Fax/Incident Report dated 9/19/10 indicated Resident #C stated that visitor (name) sat on the side of her bed to talk to her on	F0225	F225 Resident B allegations of abuse was investigated. The LPN is no longer employed by the facility. Resident C allegation was investigated. Resident received counseling and psychiatrist services for her well being. Visitor informed he could not enter facility. No actual harm noted to either resident. 2 All residents have the potential to be affected by alleged deficient practice. Allegations of abuse will be reported to Indiana Department of Health and investigated immediately by ED/Designee. **The facility policy on "Reporting Alleged Abuse" was amended to include "failure to report alleged abuse**	04/27/2011

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	Sunday evening. During this time she said he kissed her and patted her stomach area, stating that she took care of herself. (Name) then stated (name) pulled his penis out of his pants exposing his penis to her. The resident stated that the nurse (name) walked in and saw the visitor sitting on the foot of her bed and the nurse (name) asked the visitor to leave the building. A full body assessment was completed for the resident, and there were no noted injuries. Urine was collected, and the urinalysis was positive for a UTI (urinary tract injection) and an antibiotic was started. Immediate Action taken was both residents were interviewed, family notified, and physician notified. The visitor was asked not to come into the building during the investigation. A police report was made and the police investigation started. Staff was re-inserviced on abuse. An inservice was also given for after hours visitors. Preventative measures taken were the roommates were immediately separated, one to the other side of the building. Staff monitored Resident #C, and referrals were made		**immediately upon occurrence or allegation will result in corrective action."** 3.) Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on types of abuse, reporting abuse, procedures of and investigation of abuse by Nursing Administration**. Staff will be in-serviced monthly for 3 months and quarterly thereafter on reporting potential abuse immediately to ED/Designee. ED/DON will audit 24 hour report daily M-F for potential abuse, incidents and accidents and review resident, family and staff complaints. The ED/DON is on call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet for immediate notification. All new staff will be informed of abuse policies in orientation and in ongoing education.** 4.) Allegations of abuse will be reported to Performance Improvement Committee monthly. 5.) The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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	to senior counseling and a psychiatrist for Resident #C's well being. The documentation indicated they were unable to substantiate allegations, and the police investigation continues. This was the initial and follow up report. Review of witness statements by the CNA who was taking care of Resident #C that night indicated "A man came in to visit (name) (Resident #C's roommate). The man was her son, when he came in he said 'Hi' then he just stood by the door and watched TV and was talking to (name) mother. A few days before this, one of the day aides told me that (Resident #C) said that one of her roommate's visitors came and tried to kiss her. So when I seen her son come in I kept an eye on them. Nothing happened. When a call light came on, I told the nurse what the CNA had told me and that if he could just keep an eye on them while I went to get the call light. It was just for their safely because I wasn't sure what was going on or even if that was the visitor that was coming on days. When I got back out of the room that I was giving care to, the nurse told me he had to ask the man to leave because he tried to kiss (Resident #C). Again I have not seen anything for myself. So I then went to			

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	(Resident #C's) room to check on her and her roommate. They acted fine so I asked (Resident #C) if she needed any help into her night-gown. She said sure but she had already changed into one of her own nightgowns. I began to help her back into bed, then she said, 'That man tried to kiss me.' and I said 'I know that's why the nurse asked him to leave. Did anything else happen?' She then answered 'No'. After making sure she was fine, I began to leave. She then said, 'He tried to rape me.' I asked her what do you mean?' She said 'He tried to kiss me.' So I went out to tell the nurse and he said 'He just tried to kiss (name) and he seen that so he told him he had to leave.' With me not seeing anything, I told my supervisor what I heard. Then he was the one that seen the action." Review of the witness statement from the RN on duty that evening indicated "The time would have been around 7 p.m. Sunday, September 19, 2010. Sometime during the beginning of my med pass a CNA came up to me and said (Resident #C) said that her roommate's son wants to kiss her. The aide then followed with 'but you know sometimes (Resident #C) gets confused.' I continued to pass a med or two then went to their room. When			

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	I entered the room the resident's privacy curtains were wide open and (Resident #C's) roommate introduced her son, but I don't remember his name. (Resident #C) was sitting in her chair by the dresser and this man was standing about 4-5 feet away near the end of the bed with a night gown in his hand facing the resident. It seemed out of place because his mother was already in bed, and he was not facing towards his mother as if to assist her. He was fully clothed, and I did not see his penis exposed. I noticed a strong odor of etoh (alcohol). I told him my name and as precaution and I told him he would have to leave now. He put the nightgown down and left and I don't recall him saying anything to me or his mother on the way out. I looked out the door and saw this guy walking down 100 hall toward main entrance. I helped (Resident #C) with her nightgown and continued my med pass." Review of another witness statement by the Assistant Director of Nursing at that time, indicated on 9/20/10 indicated Resident #C had reported to her that her roommate's son tried to kiss her last night. She then reported the allegation to the Director of Nursing.			

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Review of the investigation report indicated the incident was not reported promptly to the Administrator or the Director of Nursing. The Director of Nursing was notified at 3:30 p.m. on 9/20/11.

Interview with the Director of Nursing on 3/25/11 at 12:30 p.m., indicated she was not the Director of Nursing at the time of the incident. She also indicated the Administrator had also left the facility and was employed elsewhere. The Director of Nursing indicated the allegation of abuse was not reported timely to the Administrator or the Director of Nursing nor was the allegation of sexual abuse investigated timely.

2. **The allegation of verbal abuse for Resident #B was reviewed on 3/25/11 at 10:30 a.m. The incident date was Sunday 9/26/10. The brief description of the incident was the r**esident was in the dining room when a nurse (named), talking in a loud voice, told the resident to eat "because she was not going to lose weight on her watch."

The immediate action taken was an investigation was started, Executive Director notified, employee suspended, physician notified and family notified.

The preventative measures taken were to have Social Service follow up with the resident and to re-educate staff on the abuse policy.

Review of the witness interview form dated 9/29/10 by the dietary employee who witnessed the verbal abuse indicated "I (name) observed a staff member telling a resident that she at least has to eat 50% of her dinner or she couldn't be moved out of

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	dining room or could not go to bed. She also stated she wasn't gonna allow her to lose weight on her watch. Then I left out of the dining room to go back to the kitchen. I came back to clean the dining room. I heard the resident crying (she always does) and the same staff member (name) came into give meds and she asked her to stop crying and if she doesn't, her aide will get mad at her and not put her to bed." Review of another witness interview dated 9/29/10 by the dietary supervisor on duty on Sunday 9/26/10 indicated "Dietary Aide (name) want to ask me a question about if someone could force a resident to eat. She stated that (name) told resident that she had to eat 50% of her food or she would have to sit up in dining room she was not going to be a weight loss on her watch. She told me I had to report to (name) my supervisor." Review of another witness statement dated 9/30/10 by the a.m. supervisor/cook indicated on Monday 9/27/10 (name) came to me about some abuse she witnessed on Sunday 9/26/10. She told me she had told (name) supervisor/p.m., after she witnessed it. (Name) Dietary Manager was not here and (name) the p.m., supervisor would not be here Monday either. I told her we would not wait for them so we went to (name) the ADON on that Monday and reported everything to her, she took her statements and said she would investigate the matter. Review of the Suspension Form indicated the LPN was suspended on 9/29/10 three days after the incident. Review of the Termination form indicated on 10/4/10 the employee was terminated from employment.			

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	Review of all the witness forms and the Physician Notification form indicated they all had the date of 9/29/10 (three days after the allegation had happened and was witnessed). Review of the staffing sheet for 9/26/10 indicated the LPN that had allegedly made those statements to the resident was not immediately removed from the facility and continued to work. Interview with the DON on 3/25/11 at 11:30 a.m., indicated she was not employed at the time of the incident, and the Administrator at that time was no longer employed at the facility. The DON indicated the Administrator nor the Director of Nursing at the time, were promptly notified of the allegation of verbal abuse. She further indicated the LPN did not leave the facility immediately and continued to work the rest of the shift. The DON further indicated the allegation of verbal abuse was substantiated by the facility. **This federal tag relates to complaint IN00087416.** **3.1-28(c)** **3.1-28(d)**			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their Abuse Policy related to promptly reporting and investigating allegations of sexual and verbal abuse and ensuring the residents	F0226	F226 Resident B allegation of abuse was investigated and the LPN is no longer employed by the facility.Resident C allegation of abuse was investigated and visitor informed he could not enter facility again. Resident received senior	04/27/2011

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	were protected from further abuse, for 2 of 4 allegations reviewed for abuse for 2 of 4 residents reviewed for abuse in the sample of 40. (Resident #B and #C) Findings include: Review of the current and undated Reporting Alleged Abuse Policy, provided by the Director of Nursing, indicated "All personnel, resident, families, and visitor are encouraged to promptly report incidents of suspected resident abuse and/or neglect to facility administration. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g. bruising and skin tears) will be promptly reported to the administrator and/or director of nursing. The person observing an incident of a resident abuse or suspecting resident abuse will immediate such incidents to their immediate supervisor and/or charge nurse. The supervisor and/or charge nurse will illicit the following information when the incident is reported: the name of the resident, the date and time of the incident, where the incident took place, the names of the persons committing or involved with the incident and the name of any witnesses. If the		counseling and psychiatric services for her well being. No actual harm noted to either resident. 2. All residents have the potential to be affected by the same deficient practice.Allegations of abuse will be reported to Indiana Department of Health and investigated immediately by ED/Designee. **The facility policy on "Reporting Alleged Abuse" was amended to include "failure to report alleged abuse immediately upon occurrence or allegation will result in corrective action."** 3.) Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on types of abuse, reporting abuse, procedures of and investigation of abuse by Nursing Administration**. Staff will be in-serviced monthly for 3 months and quarterly thereafter on reporting potential abuse immediately to ED/Designee. DON/Designee will audit 24 hour report daily M-F for potential abuse, incidents and accidents and review resident, family and staff complaints. The ED/DON is on call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet for immediate notification. All new staff will be informed of abuse policies in orientation and in ongoing education.** Allegations of abuse will be reported to Performance Improvement Committee monthly. The DON is responsible for ensuring ongoing compliance. Compliance date is 04/27/11.	

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LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360

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	accused individual is an employee, they will be placed on suspension pending results of the investigation while the incident is being investigated. 1. Review of the Fax/Incident Report dated 9/19/10 indicated Resident #C stated that visitor (name) sat on the side of her bed to talk to her on Sunday evening. During this time she said he kissed her and patted her stomach area, stating that she took care of herself. (Name) then stated (name) pulled his penis out of his pants exposing his penis to her. The resident stated that the nurse (name) walked in and saw the visitor sitting on the foot of her bed and the nurse (name) asked the visitor to leave the building. A full body assessment was completed for the resident, and there were no noted injuries. Urine was collected, and the urinalysis was positive for a UTI (urinary tract injection) and an antibiotic was started. Immediate Action taken was both residents were interviewed, family notified, and physician notified. The visitor was asked not to come into the building during the investigation. A			

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	police report was made and the police investigation started. Staff was re-inserviced on abuse. An inservice was also given for after hours visitors. Preventative measures taken were the roommates were immediately separated, one to the other side of the building. Staff monitored Resident #C, and referrals were made to senior counseling and a psychiatrist for Resident #C's well being. The documentation indicated they were unable to substantiate allegations, and the police investigation continues. This was the initial and follow up report. Review of witness statements by the CNA who was taking care of Resident #C that night indicated "A man came in to visit (name) (Resident #C's roommate). The man was her son, when he came in he said 'Hi' then he just stood by the door and watched TV and was talking to (name) mother. A few days before this, one of the day aides told me that (Resident #C) said that one of her roommate's visitors came and tried to kiss her. So when I seen her son come in I kept an eye on them. Nothing happened. When a call light came on, I told the nurse what the CNA had told me and that if he could just keep an eye on them			

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	while I went to get the call light. It was just for their safely because I wasn't sure what was going on or even if that was the visitor that was coming on days. When I got back out of the room that I was giving care to, the nurse told me he had to ask the man to leave because he tried to kiss (Resident #C). Again I have not seen anything for myself. So I then went to (Resident #C's) room to check on her and her roommate. They acted fine so I asked (Resident #C) if she needed any help into her night-gown. She said sure but she had already changed into one of her own nightgowns. I began to help her back into bed, then she said, 'That man tried to kiss me.' and I said 'I know that's why the nurse asked him to leave. Did anything else happen?' She then answered 'No'. After making sure she was fine, I began to leave. She then said, 'He tried to rape me.' I asked her what do you mean?' She said 'He tried to kiss me.' So I went out to tell the nurse and he said 'He just tried to kiss (name) and he seen that so he told him he had to leave.' With me not seeing anything, I told my supervisor what I heard. Then he was the one that seen the action." Review of the witness statement from the RN on duty that evening indicated			

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	"The time would have been around 7 p.m. Sunday, September 19, 2010. Sometime during the beginning of my med pass a CNA came up to me and said (Resident #C) said that her roommate's son wants to kiss her. The aide then followed with 'but you know sometimes (Resident #C) gets confused.' I continued to pass a med or two then went to their room. When I entered the room the resident's privacy curtains were wide open and (Resident #C's) roommate introduced her son, but I don't remember his name. (Resident #C) was sitting in her chair by the dresser and this man was standing about 4-5 feet away near the end of the bed with a night gown in his hand facing the resident. It seemed out of place because his mother was already in bed, and he was not facing towards his mother as if to assist her. He was fully clothed, and I did not see his penis exposed. I noticed a strong odor of etoh (alcohol). I told him my name and as precaution and I told him he would have to leave now. He put the nightgown down and left and I don't recall him saying anything to me or his mother on the way out. I looked out the door and saw this guy walking down 100 hall toward main entrance. I helped (Resident #C) with her nightgown and continued my med			

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	pass." Review of another witness statement by the Assistant Director of Nursing at that time, indicated on 9/20/10 indicated Resident #C had reported to her that her roommate's son tried to kiss her last night. She then reported the allegation to the Director of Nursing. **Review of the investigation report indicated the incident was not reported promptly to the Administrator or the Director of Nursing. The Director of Nursing was notified at 3:30 p.m. on 9/20/11.** Interview with the Director of Nursing on 3/25/11 at 12:30 p.m., indicated she was not the Director of Nursing at the time of the incident. She also indicated the Administrator had also left the facility and was employed elsewhere. The Director of Nursing indicated the allegation of abuse was not reported timely to the Administrator or the Director of Nursing nor was the allegation of sexual abuse investigated timely. 2. **The allegation of verbal abuse for Resident #B was reviewed on 3/25/11 at 10:30 a.m. The incident date was Sunday 9/26/10. The brief description of the incident was the r**esident was in the dining room when a nurse (named), talking in a loud voice, told the resident to eat "because she was not going to lose weight on her watch." The immediate action taken was an investigation was started, Executive Director notified, employee suspended, physician			

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	notified and family notified. The preventative measures taken were to have Social Service follow up with the resident and to re-educate staff on the abuse policy. Review of the witness interview form dated 9/29/10 by the dietary employee who witnessed the verbal abuse indicated "I (name) observed a staff member telling a resident that she at least has to eat 50% of her dinner or she couldn't be moved out of dining room or could not go to bed. She also stated she wasn't gonna allow her to lose weight on her watch. Then I left out of the dining room to go back to the kitchen. I came back to clean the dining room. I heard the resident crying (she always does) and the same staff member (name) came into give meds and she asked her to stop crying and if she doesn't, her aide will get mad at her and not put her to bed." Review of another witness interview dated 9/29/10 by the dietary supervisor on duty on Sunday 9/26/10 indicated "Dietary Aide (name) want to ask me a question about if someone could force a resident to eat. She stated that (name) told resident that she had to eat 50% of her food or she would have to sit up in dining room she was not going to be a weight loss on her watch. She told me I had to report to (name) my supervisor." Review of another witness statement dated 9/30/10 by the a.m. supervisor/cook indicated on Monday 9/27/10 (name) came to me about some abuse she witnessed on Sunday 9/26/10. She told me she had told (name) supervisor/p.m., after she witnessed it. (Name) Dietary Manager was not here and (name) the p.m., supervisor would not be here			

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	Monday either. I told her we would not wait for them so we went to (name) the ADON on that Monday and reported everything to her, she took her statements and said she would investigate the matter. Review of the Suspension Form indicated the LPN was suspended on 9/29/10 three days after the incident. Review of the Termination form indicated on 10/4/10 the employee was terminated from employment. Review of all the witness forms and the Physician Notification form indicated they all had the date of 9/29/10 (three days after the allegation had happened and was witnessed). Review of the staffing sheet for 9/26/10 indicated the LPN that had allegedly made those statements to the resident was not immediately removed from the facility and continued to work. Interview with the DON on 3/25/11 at 11:30 a.m., indicated she was not employed at the time of the incident, and the Administrator at that time was no longer employed at the facility. The DON indicated the Administrator nor the Director of Nursing at the time, were promptly notified of the allegation of verbal abuse. She further indicated the LPN did not leave the facility immediately and continued to work the rest of the shift. The DON further indicated the allegation of verbal abuse was substantiated by the facility. **This federal tag relates to complaint IN00087416.** **3.1-28(a)**			

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